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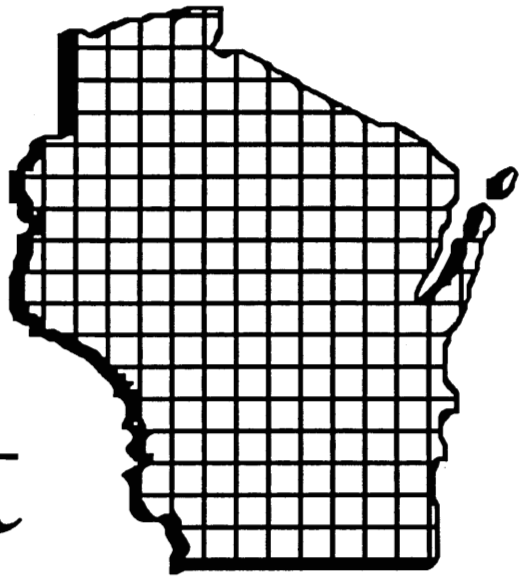

August 1993 Volume 6, No. 7

INNOVATIVE APPROACHES TO HEALTH CARE IN WISCONSIN

A Review of Three Business-Initiated, Alternative Health Care Plans

Report from the President

There is no issue in the United States, or in the State of Wisconsin, that will be more talked about over the next year than health care. We asked Professor Sammis White, the former director of the Urban Research Center at the University of WI-Milwaukee, to examine several new creative programs that are now being used by businesses in Wisconsin.

While the health care debate will start this Fall, it is clear that any Federal plan will take several years to enact. It is conceivable that it will not even be in place until the start of the twenty-first century. That is why we thought it would be important to examine how businesses are coping with rising health care costs.

A number of states besides Wisconsin have begun developing ideas to solve the health care quagmire at the state level. It will be very important in the future to have this kind of involvement because of the amount of time it will take the Federal government to implement new programs, although this involvement is mandatory because of the enormous costs of Medicare and Medicaid.

It will be equally important to have consumers demanding that the cost for health care drop as soon as possible. That is the crux of this particular study. We chose three different approaches that are now being used in Wisconsin. At first glance, they appear to be very successful. Health care costs can be controlled when consumers begin to pull together and work out agreements with the health care industry that can begin to put caps on the enormous spending that has occurred over the last decade. These preliminary results are very encouraging.

James H. Miller

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by

Sammis B. White, Ph.D.

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Sammis B. White, Ph. D.

EXECUTIVE SUMMARY

The health care system in the United States is not healthy. Health care costs are high and have been rising at four times the rate of inflation in recent years. Despite the high and rising costs, there are numerous problems of inappropriate and low-quality health care. And some 15% of Americans are not covered by health insurance. It is no wonder that a system consuming 14% of gross domestic product is at the top of the national agenda for change.

Numerous Wisconsin businesses struggling to compete in the international economy are also struggling with how to contain health care costs and make their workers healthier and more productive. Several companies have taken innovative steps to address these issues, steps that are in keeping with their private-market philosophies. Three of these innovative efforts are described in this report. None of these efforts has been in place long enough to know for certain that it works. But all contain elements that appear to belong in a successful prescription, and early responses to them are positive.

These programs all involve "managed care;" that is, some control over access to the system. But all are trying to make the "market" work, reducing the inefficiencies caused by lack of information. Common elements included in at least two of the three are:

Partnership -- of patient, provider, and payer

Fee Reductions -- for both physicians and hospitals; agreements may also include other providers and pharmacies

Consumer Involvement

- as a partial payer, to increase competitive choices and informed use
- as a student, to learn how, when, where, and why to access the health care system
- as a watchdog over provider charges
- as a consumer of health, practicing a healthier lifestyle

System Monitoring and Publicizing

- of prices and services
- of quality outcomes

System Change

- use gatekeepers; primary-care physicians
- reduce inefficiencies in administration and health care provision
- educate providers as well as patients, payers

Evolution -- continuous change as components of the system are analyzed

Containing health care costs is an extremely complex undertaking. Controlling costs, increasing health care quality, and improving access is even more challenging. The fact that both the current proposal of President Bill Clinton and two of our models employ the use of alliances of employers to purchase health care services suggests that this is a very good place for others to start. We know few details of the Clinton proposal, but given the logic found in our three Wisconsin models, the federal plan should contain many of the same elements. Since any federal effort is likely to take years to implement and health care costs will likely continue to rise at close to recent rates, employers would be well-served to examine these three models and take their own steps to address health care issues. The results are not guaranteed, but the evidence to date is very encouraging.

Introduction[1]

Health care cost containment is at the top of many American agendas. With health care costs exceeding $939 billion in 1992, consuming some 14% of gross domestic product, and rising at 12% per year, it is no wonder. But health care *costs* are only part of the health care problem. *Quality* of that care is another issue. Symptomatic are findings by the RAND Corporation which indicated rates of inappropriate care ranging from 14% (for coronary artery bypasses) to 32% (for carotid endarterectomies),[2] and other estimates that between 25% and 40% of all medical tests and procedures are unnecessary.[3] The third component of the health care problem is *access*. An estimated 34 million to 37 million Americans lack health insurance of any kind. Some three-quarters of the uninsured are employed or are the dependents of employees; of the uninsured employees, some two-thirds are employed in businesses with 25 or fewer employees, making access very much an issue for small businesses.[4] It is no wonder that Americans from the President and his wife on down want to find solutions to these problems.

Here in Wisconsin, many businesses have not been willing to wait for others to find solutions. They have been frustrated by their own searches for solutions. Traditional answers have failed. New answers are required. This study reports on three attempts by Wisconsin businesses to approach health care provision differently. The new "solutions" described herein have not yet withstood the test of time. All, however, have been implemented, and all seem to contain elements that are essential if we are to truly rein in health care costs and provide better health care to all Americans. These Wisconsin "solutions" also seem to show that private-market approaches are possible if the market is established in a way that allows it to function.

Why are health care costs a concern?

Health care costs for Wisconsin employers (and those elsewhere in the country) are too high to allow these companies and their products to be competitive in the world economy. Employers in the state have a number of options for dealing with the cost competition they face from abroad. The most obvious deals with wages. But the second most obvious deals with benefits, most notably health care benefits. Employers can address health care benefits in a number of ways, most of which are detrimental to the communities in which they are located. Ideally, from the community's perspective, employers will grow or at least maintain employment where they are currently located.

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1 The author wishes to thank three individuals who gave freely of their time and information about the three health care models discussed in this paper: Mr. Tom Belot, President of the Vollrath Company in Sheboygan; Dr. Sam Romeo, Vice President for Clinical Practice Development, Medical College of Wisconsin; and Ms. Josephine Musser, current Commissioner of Insurance for the State of Wisconsin and former Director of The Alliance in Madison. Any errors in the description of their programs are entirely the author's.

2 Peter Magowan, "A Great Prognosis for 'Play or Pay,'" *The Wall Street Journal*, March 26, 1992, p. A15.

3 Ron Wilson, "Fourteen Minneapolis Firms to Set Up Coalition to Lower Health Care Costs," *The Wall Street Journal*, July 1, 1992, p. B2.

4 W. David Helms, Anne K. Gauthier, and Daniel M. Campion, "Mending the Flaws in the Small-Group Market," *Health Affairs*, Summer 1992, pp. 7-27.

But faced with high and rapidly rising health care costs, employers may look to move elsewhere, shift a greater portion of the health care cost burden to employees (deductibles and co-payments or no insurance at all), hire workers who do not qualify for benefits, or control health care costs in some other way so as to remain competitive in place. The last option is obviously the least painful for all parties concerned and would yield the greatest benefits to Wisconsin, its employers, and its citizens, if done properly. The issue is whether health care costs can be contained.

History to date makes one wonder. Wisconsin health care costs are approximately 20% below those nationally. But both Wisconsin and national costs are growing at about four times the rate of inflation. Most of the techniques derived in the last decade to control costs have failed. And many of the current proposals are doomed to also fail. Several examples serve to illustrate the futility of some of these techniques.

One of the more popular recent approaches is for employers to band together and purchase health services in bulk, demanding a cut in rate from providers in exchange for larger volume. That seems like an acceptable *quid pro quo*.[5] While it delivers some immediate savings to those covered, however, it fails on two counts. It is likely to bid up costs to those not covered by the arrangement, and it may not do anything to reduce future increases in costs -- they merely start from a lower base.

A similar model steers patients to providers who in turn give a discount for volume. This has appeal because rates are cut initially in order to get patients. But, over time, the anointed providers can bid up prices because there is less competition after the early years. This is a model that was to give less control to the providers, but in fact in time it gives them more.

Another option that has proven popular but increasingly less successful is the hiring of utilization review companies. Under this option, an employer hires a third party to question the necessity of both the recommended treatment and treatment already administered. The theory is that medicine is not being practiced in a cost-effective manner and that these variances can be caught by the vigilant cost-review companies, for a fee. Initially, that was true. In a study cited in *The Wall Street Journal*, 223 insured groups that were subject to utilization reviews between 1984 and 1986 had their hospital admissions rate cut 13% and overall medical cost reduced by 6%. But as the number of groups covered by utilization reviews increased from 3% in 1984 to 80% in 1992, the law of diminishing returns set in. The returns today on medical costs are estimated at 2% to 5% and declining. What is worse is that all of these reviews have greatly burdened the health care providers, who must respond to all of the inquiries. They have added staff whose cost may now exceed the savings. In other words, the supposed cost savings is just being shifted and added to the same bills that are supposedly in question.[6] Furthermore, neither the employer nor the employees are involved, so there is no communication that can help to reduce future costs.

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5 An article in *The Milwaukee Journal* last year discussed the savings realized by one company that provides managed care health services to clients of national insurers, Associates For Health Care, Inc. The company reported that it was averaging a 23% discount from the hospital providers and 17% from the physicians.

6 Thomas Burton, "Firms That Promise Lower Medical Bills May Increase Them," *The Wall Street Journal*, July 28, 1992, pp. A1, A6.

Another model steers demand to the doctors who are considered to be the best or who best follow prescribed practices. This steering of demand sounds good initially because it rewards those who are doing what may be most cost-effective. But soon the "good guys" get overloaded and can take no more patients. The system is then in a quandary as to what to do next. Inevitably, one must use most of the providers who are out there. The charge is to get more of them to practice in the preferred ways.

Yet another model that some employers have used successfully, at least initially, is the hiring of a consultant who reviews charges and determines how much the employer is willing to pay for specific services. Not only has this model been increasingly less successful in saving money as providers have narrowed their range of fees, the consultant takes a fee for work which further minimizes the net savings.

Many of these approaches have been given specific names and acronyms. Chart 1 on the next page details several of the current health care acronyms and the approaches they represent. The distinction among them is continuously blurring as initial assumptions on how each would work is modified by experience. We have basically changed from a system of free choice to one of "managed care." The degree of management varies, but almost all of the more recent approaches involve management and restrictions. The original indemnity insurance is still offered, but it is not often the full coverage that seemed to work so nicely a decade ago. Basically, under full indemnity, an employee's health care costs are covered and employees have free choice as to where to be serviced and by whom. Health maintenance organizations (HMOs), a second-generation construct, provide enrollees with comprehensive health coverage in exchange for fixed, periodic payments. The appeal to employers and employees is that by agreeing to use a predetermined set of providers, the cost to employers and employees is lower.

Variations on these themes exist. Preferred provider organizations (PPOs), offer those persons covered a limited choice of providers in exchange for lower premiums, deductibles or co-payments. Usually, the patient is seen and screened by a primary-care physician who then refers patients, when needed, to specialists within the network. Patients willing to pay more, however, may go outside the network. Limited service health organizations (LSHOs), are stripped down plans modeled after HMOs. The patient is restricted to the designated list of providers. If the patient uses someone not on the list, the patient must pay the full cost of service rather than the difference as in the PPO model.

CHART 1: Examples of Health Care Alternatives

HMO	**Health Maintenance Organization** A network of health care providers offering services at a reduced price in exchange for exclusive access to patients. Enrollees pay full fees if they use outside providers.
PPO	**Preferred Provider Organization** A designated network of health care providers trading lower fees for access to patients. Patients pay little (10% or nothing) for services from the network and 20%-30% of fees if they use non-network providers.
POS-HMO	**Point of Service Health Maintenance Organization** Similar to, but more flexible than, an HMO; patients may use services outside the designated network, after checking with a primary-care physician and after agreeing to pay higher out-of-pocket expenses (10%-15%).
LSHO	**Limited Service Health Organization** Very similar to an HMO in that a patient receives full- or reduced-price service from the network of providers, but pays all fees for using non-designated providers. Providers receive a fixed fee for each patient, as opposed to pay per service.
TPA	**Third Party Administrator** Hired by employers that self-insure (some 80% of those with more than 100 employees) to monitor the health care bills, to ensure that appropriate charges and payments are made.
URC	**Utilization Review Company** Private firm that, for a fee, aggressively questions the necessity of both recommended treatments and treatments already received.

In these models and the myriad variations of them, the employer and employee are making a series of trade-offs to reduce costs. Choice is the most common bargaining chip, but cost-sharing is another. Most of the efforts to date, regardless of their acronym, have as their main focus cost containment. The issue is saving money directly and immediately, not looking to the implications for the future and often not looking at quality issues. Despite this focus and the spread of efforts to control costs, costs still rose 12% in 1992. Obviously, health care cost containment is an extremely complicated endeavor.

The approaches just reviewed are certainly being employed in Wisconsin. But given their shortcomings, it is no wonder that employers have been frustrated with the results. Fortunately, several innovative efforts are underway in Wisconsin to address the continuing frustration. Most of these efforts are business initiatives, but even the state government has been driven to launch an effort to contain health care costs, the proposed Wisconsin Health Care Partnership Plan.

Given the last decade of failed attempts to contain health care costs, can any of these new efforts succeed? Can any of the attempts do more than shift the burden from one party to another? We do not know the answers as of yet. But some of the new attempts by businesses in Wisconsin to reduce health care costs are worth exploring because they contain new elements that may well succeed in better containing costs and addressing the other critical issues in health care. The three we review are not necessarily the three best in the state, but they are good examples of current attempts to address not only health care cost containment but also other areas of health care issues as well.

Not all three examples have proven track records, but they are examples of alternative ways to address the issues, and they do contain several common elements that more persons are realizing are essential components if more than very short-term savings are to be realized. The hope is that by sharing the details of these attempts, other employers will find elements that they will want to employ in their own quests to contain costs and better serve their employees and themselves.

SEARCH

SEARCH is the acronym given to the Sheboygan Employers Aligned to Reduce Costs of Health care, an alliance of some 30 companies organized to better address the one cost of doing business that they had been unable to control. The alliance grew out of the frustration of one chief executive officer (CEO), Tom Belot of the Vollrath Company, who decided that to help his company and all of Sheboygan County, the health cost issue must be addressed.

Some 50 leading CEOs in Sheboygan County were invited to the initial meeting. All but two attended. They reached two conclusions: 1) they were ill informed of their options; and, 2) they could not solve the problem themselves. They sent out a request for proposals to help them sort through alternatives. They chose a Green Bay preferred provider organization to undertake a six-month study of their situation in Sheboygan.

The recommended new approach dealt with the application of information and the steering of clients to designated health care providers. The consultant provided the employers with a list of physicians and hospitals along with their charges by procedure. This information allowed the alliance to seek common, lower fees for all the employees in their organizations.

The three hospitals in Sheboygan County agreed to accept lower fees and to guarantee a low rate of increase over a period of years, in part because of the threat of SEARCH members taking their business elsewhere. The size of this threat was unknown at the time of negotiation because the formal commitment of employers to the plan had not yet emerged. Nevertheless, the hospitals were willing to reach a compromise.

Physicians were another story. About half of the doctors in the county are affiliated with the Sheboygan Clinic and work under one roof; the other half is made up of independent practitioners. The alliance approached them all with the proposal that the fees to which they agreed would match those of the lowest-priced physician group. (The lowest-priced group further muddied the waters by quoting an even lower rate to SEARCH if they would steer patients to them.) In any event, the Sheboygan Clinic voted not to do business with SEARCH and, in fact, has attempted to establish a competing organization that steers patients to their Clinic. Most of the independent physicians agreed to participate with SEARCH at the lower fees in exchange for the steering of patients to them.

The final plan, however, is different from that offered by many others in Wisconsin in that there is greater flexibility for employees and their families covered by SEARCH. Each company can take advantage of rates as they see fit. The hospital rates are set for all participants. But while physician rates are largely set, not all patients must use the designated doctors. Companies must attempt to steer patients to the chosen doctors, and they do so with an agreement on co-payments or deductibles. The companies will reimburse or pay the doctors what has been determined is a "reasonable" fee. An alternative is for companies to use a set of fees established by the original consultant in its network in Green Bay. If the patient chooses to go outside the provider network, the patient is responsible for the difference between the designated rate and the outside physician's fees.

To help ensure certain behavior, such as annual check-ups, some companies provide free annual physical exams if employees and their families use specific physicians. This is another form of steering.

One of the benefits of the SEARCH approach is the cost savings that are realized. Most of the employers are self-insured. They, therefore, immediately feel any savings that accrue from lower physician and hospital fees. Another benefit for employers is the lack of need for intensive management of health care. They do not bother with the cumbersome management of HMOs, which require permission for appointments and procedures. As long as those persons covered use the system, they are not encumbered by the process or the paperwork.

Companies pay $1.50 per month per employee to the consultant to monitor the steerage to physicians. But that is the only extra cost, and it is modest. Furthermore, employers have found some insurance companies that are well informed about the rules, prices, and steerage policies so they can afford to charge lower rates. Small employers can switch to any of four local insurance companies who offer very competitive rates. The result is that SEARCH members are realizing substantial savings in health care costs.

Employees benefit from this plan by experiencing a reduction in health care costs and a decrease in the rate at which health care costs have risen. They have complete freedom of choice of physicians, if they are willing to pay extra for it. Otherwise, they can choose from among half of the doctors in the county. The cost savings have also helped to preserve their jobs, since their employers are now more cost competitive. Many companies restrict the plan to Sheboygan providers, so that employees who get sick while in Madison

are not covered there. A few companies indicate that they will cover costs anywhere, but encourage employees to come back to Sheboygan for any extended care.

Benefits to Others

One concern leaders of SEARCH had is whether they were creating benefits for themselves at the expense of others. Were they cost-shifting to others by obtaining lower rates for which providers would then compensate by charging others higher rates? SEARCH did not want to be in this position. Whether they *are* is not clear. The hospitals have clauses in their contracts with SEARCH promising not to shift costs to other payers. Given that marketing and administrative costs can rise to nearly 40% of total costs, having a large number of potential users come in all signed-up does allow some room for cost savings and rate reduction.[7]

The deal with the physicians is not as clear. But the selling point to the physicians appears to be the provision of clients. They want new patients and are willing to reduce rates to increase the demand for their services. The trade-off, again, is the reduction in marketing expenses realized.

Underdeveloped Elements

This plan has brought about cost reductions for employers and employees. But how long these cost savings can be maintained is open to question. The one major element that is missing, which others now think is essential, is patient involvement. Some of the employers have wellness programs, but many do not. Most employers offer free annual check-ups, but there are no incentives to modify behavior and lifestyles. This element is under discussion, but not yet an integral part of the plan.

The original plan also had no designated gatekeepers for access to health care. One recent study, part of the national study entitled Medical Outcomes, revealed that differences in physician specialty greatly affect the cost of health care. It found that cardiologists, for example, hospitalized patients at twice the rate of family practitioners. The study concluded, as have many HMOs, that a health care system based on family doctors and internists would be much more cost-effective than one dominated by specialists.[8] SEARCH is now trying to use family practitioners as the access point. They are paying higher fees to family care and reducing payments to specialists to initially steer patients to family-care physicians.

At this point, the amount of management of the health care system in the SEARCH approach is modest compared to many alternatives. Its consultant receives the service claims, reprices them, and sends them on to be paid by the third parties, either the employers or their insurers. The consultant reports on the utilization of services and their costs, both for those covered by SEARCH and those not covered. SEARCH members can then make informed judgments about what steps may need to be taken to modify their approach to health care utilization. So far, employers are pleased with the response of the physicians. SEARCH members see less use of lab work and x-rays, fewer appointments, shorter appointments, and greater assessment of the value of any procedures.

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7 Helms, Gauthier, and Campion, "Mending the Flaws," *supra* note 4, at p. 10.

8 *See* "Differences in the Mix of Patients Among Medical Specializations and Systems of Care," *The Journal of the American Medical Association,* March 25, 1992, pp. 16-17.

An element that is utilized, but which is not present to the desired degree in the program, is specialist physicians. SEARCH has all major specialties covered, but there are some gaps in certain sub-specialties. It covers these now by agreeing to bring in outsiders and paying their (usually) higher fees. In the future, the hope is that it will be able to have such persons on staff. It also hopes to have a few more family practitioners, since these doctors are now extremely busy with their current caseloads. SEARCH could use more of these because they are gatekeeping by handling more health needs themselves, passing on fewer referrals to the specialists.

Replicability

This model can be replicated, but perhaps not in every market. SEARCH was established by 30 of the original 50 employers asked to attend the first meeting. The group has grown to 35 employers, with others under consideration. The employers range in size from two to 1,300 employees, and they together employ about 8,000 workers. Combined with their families, these workers total 20,000 persons, or approximately 20% of the county's population. It is the scale of their presence which has given them the power to contract for lowered fees and to gain cooperation from the hospitals and many physician groups. Joining the group is easy and inexpensive, and the health care coverage is as good as employers want to make it. There is no need to gut one's coverage or to pass on new costs to the employees in order to reduce health care costs, at least not at this time.

SEARCH needed to enroll about 20% of the population to get a hearing from the providers. If SEARCH was very successful and was able to enroll 70%-80% of the population, this approach would not have worked. The providers could not have handled the increased level of activity. There seems to be a window in which such an approach can work.

SEARCH is just getting started and is continuing to explore what is needed to make its system work better. It sees the key as working with the providers. SEARCH is seeking ways to make life easier for the doctors. At this juncture, it provides documents, a plan, pre-certification, and one party to oversee the administration. This alone reduces overhead and speeds claims' payments. It wants to go even further in this direction, so that administrative costs are diminished even more. SEARCH also helps in the recruitment of new doctors to Sheboygan because it can demonstrate some minimal level of demand.

Two employer types have had some trouble entering the SEARCH program. One is unionized firms that have not allowed the introduction of the notion of steering patients to specific providers. This will be a barrier as long as the unions want it to be. The cost differential may force the issue, but until it does, such firms must not participate. The second type that has had troubles participating is made up of those firms which are already involved in insurance plans. Many firms are locked into plans either by design or tradition. SEARCH has helped some of these by being a visible alternative. Small employers can demand better rates, rates that more nearly match those of SEARCH, from their insurance plan providers. Thus, even by not joining, non-participating firms may reap some benefits from this approach.

If employers elsewhere are to consider this SEARCH model, they should learn more about the modifications now in progress. Further long-run cost savings from employee changes in lifestyle may become an important component. Other changes are also in the wings. The commitment is here, as is the potential for further savings. When they will be realized by SEARCH members remains to be seen.

MCW-Johnson Controls

A very different model, and one that is also still in its early stages, is the cooperative agreement between the Medical College of Wisconsin (MCW) and Johnson Controls (JC). The Medical College is to provide "managed care" for Johnson Controls and act as the medical director, assembling the networks of physicians, hospitals, and other providers that are needed to offer Johnson Controls' employees and their families complete health care. Initially conceived of as an experiment to be conducted at headquarters in Milwaukee, the implementation has involved four states; five more are currently being added, and others are likely to be added in the future. Rather than being an experiment on a small scale, then, the initial operation now involves 10,000 Johnson Controls employees and their families in four states, with more coming.

Johnson Controls was driven to the large-scale involvement by two distinct forces. The first was a company-wide attempt to implement total quality management (TQM), which involves much greater sharing of decision-making. The administration at headquarters realized that it could not force a new approach to health care on outlying plants now that each had new autonomy for their own decisions. To counteract the top-down imposition, JC decided to implement the new health system in stages, but much larger stages than had originally been contemplated. Thus, the JC operations in four states were chosen for the first year of implementation.

The second reason for the push to four states was the complete frustration of JC to control health care costs. It felt that it had tried everything, and nothing worked. When it was approached by MCW, it was willing to listen. MCW wanted to get involved in managed care for several reasons, not the least of which was the desire to educate its students. MCW wanted to teach its students about the new model of health care delivery they will all be experiencing, "managed care." MCW also wanted to teach its students not only how to practice medicine, but also how to deliver health care. Doctors will be in business, and they will need to understand how to generate a patient load for themselves. MCW saw this opportunity to link with JC to be the perfect vehicle for student education. It also contributed to MCW in terms of an increased patient load for the school and the education of its administrators.

The Philosophy

MCW became involved because of a "lucky confluence of people and beliefs," according to Vice President for Clinical Practice Development Sam Romeo, who is overseeing the initiative for MCW. He sees a meeting of cultures and a new appreciation of mutual interdependence as cornerstones of the collaborative effort. Health care provision should not just be overseen by HMOs or by insurance companies, he contends. Under the usual insurance model or most HMO models, the payers have tried to manipulate the providers. The providers, in turn, learn how to manipulate the payers, with the patients losing in the process. The preferred arrangement, the one being implemented, is one in which the patient, the provider, and the payer work together to achieve a mutually agreeable outcome. This partnership is central to success.

MCW sees itself as the coordinator between the payer and the patient, as well as the medical director who has assembled the provider network. The program works on two principals: 1) there are no secrets: fees and the like are common knowledge; and, 2) health-risk appraisal and wellness care are fundamental to cost-effective and high-quality health care delivery.

MCW has made the effort to establish a fee schedule for services that covers physicians, procedures, and hospitals in each of the four states in which JC has operations. JC is buying these services. In every market in which it operates, JC is too small to be given any volume discount. Instead, MCW publishes a set of standard fees, fees that have been determined as acceptable nationally and published by McGraw-Hill. All the providers who have agreed to be a part of the provider network agree to accept these fees. The physicians accept a standard fee and a standard code that signifies a specific treatment for a specific ailment. Those providers unwilling to accept the standard amounts are excluded from the partnership.

Physicians and hospitals were asked to join the network. MCW contacted the primary-care physicians that JC employees used in each of the four states and asked them two questions. The first was whether they would like to participate in the new provider network; the second was whom they use as consulting physicians and hospitals. Most of the persons and organizations whom they contacted agreed to participate. In sum, some 300-400 hospitals and about 4,500 physicians in the four states agreed to join with MCW. All who joined understood that MCW would share rate, treatment, and associated information with all providers, payers, and patients.

Wellness Program

The second major component of this new, managed-care approach involves the construction of a formal way to increase the wellness of the covered population. The intent of this component is to reduce the long-term costs of health care provision by creating a healthier population. The MCW approach has two elements. The first involves MCW attempting to coordinate the employee assistance programs (EAPs) which operate in all of the JC plants. EAPs are on-site health programs aimed at helping employees deal with modern life and ways employees can learn to better cope with it. They commonly deal with such issues as stress, drug and alcohol abuse, caring for elderly parents, parenting, and the like. The intent of the new effort is to make these EAPs less punitive and more educational. MCW hopes to stress early intervention rather than disease control. And they will expand the coverage from just employees to include spouses as well.

The second component of the wellness initiative is an attempt to educate each worker and each spouse about his or her health risks and how they can best be lowered. Each employee and each spouse is sent a health-risk appraisal form. Both are then requested to complete the form and take it to an appointment with their primary-care physician. The physician is then supposed to discuss possible behavior modifications with the patients. Typical topics include smoking cessation, seat-belt wearing, exercise, diet control, and stress management. Since health-risk appraisal is not natural for either the physicians or the clients, both are offered incentives to participate. The doctors are paid 100% for their involvement and advice, as opposed to 80% with a co-payment for most treatments. The patients are offered some form of rebate, at this point a book, for following through.

Whether this approach to wellness works is not known. MCW and the company must both examine the results. JC must look historically to see whether sick days, tardiness, accidents on the job, and the like are reduced as the number of persons participating in the program increases. Immediate results are not expected, so a longer-term study is required. Unfortunately, few of the companies that have histories of wellness programs have had them evaluated for their true contributions to health, as opposed to their contributions to employee satisfaction. But a study of the Adolph Coors Company in Colorado has shown that Coors saves some $2 million a year because of its wellness

program, and its rate of health cost increases were one-third the rates of other employers.[9] Such dramatic results may not occur for others. But many persons involved in health care strongly believe that wellness programs must be a central element of any long-term effort to contain health care costs.

Program Scale

The program is initially targeted at JC plants in four states, then five more states, and then beyond. Employees, however, do not have to choose the MCW network. They can elect to take the basic insurance plan with a high deductible. Usual takers of such plans are young and single, with few risks of catastrophic illness. The second option is the standard insurance plan, with a lower deductible and higher employee costs. The third is the MCW partnership, in which the employees must identify a primary-care physician and consultant who are in the network. Approximately one-third of the employees have chosen the partnership route. Because the majority of these is made up of persons with children, the new program covers about 50% of the total persons involved in JC health care programs. The question is whether this number will increase or decrease over time. That will depend on the success of the partnership.

The key issues for success include whether MCW can hold the fee schedule it is trying to establish and whether this form of "managed care" will be widely accepted. If fees are not held in check, the supposed cost savings will not materialize over time, reducing interest in the option. The issue of whether the culture will accept this concept of "managed care" is also an unknown. Employees are asked to make a trade-off between expanded choices and cost savings, and physicians are asked to trade off some fee income for greater involvement in providing wellness to a larger patient body. If the benefit/cost ratio to either group is not sufficient, the option will be rejected.

Underdeveloped Elements

This model contains many of the same elements as the SEARCH model, even if it applies to only one large company. Nevertheless, there appear to be elements that should be included here to give it a higher probability of success. Among those are greater consumer education and involvement and provider education. The MCW/JC approach does rely on EAPs and annual check-ups, but only a modest portion of employees usually take advantage of the EAPs. The messages on health and self-care are usually not widely enough distributed through this mechanism. Furthermore, annual check-ups are often not sufficient either. More thought is likely needed in this area. Changing physician practices is also an area open to further development. If doctors in certain geographic areas are not following accepted practice standards from elsewhere in the country, these patterns need to be identified and addressed.

Replicability

The jury is out, but this model is another potential route for others to try. Unfortunately, it will take a few years to learn the results. MCW is not interested in taking on any new companies at his time. It wants to evaluate its partnership more fully. At this point, the only clear measures are the impact to date on costs and the satisfaction of providers and JC employees. After one year, JC noted a "significant " decrease in the rate of inflation of costs and all groups affiliated with the partnership were "quite positive" about the results. Regardless, any notion of the impact of the wellness component will

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9 Shari Caudron, "The Wellness Payoff," *Personnel Journal*, July 1990, pp. 55-60.

take several years. MCW does believe, however, that other companies can attempt to use this same model by themselves. It stresses that the focus should be the quality of care delivered and the partnership of patient, payer, and provider -- with a secondary focus on dollars saved.

The Alliance

The Employer Health Care Alliance Cooperative, known as the Alliance, is based in Dane County and has new-service initiatives in five other Wisconsin communities. The Alliance is another form of "managed care." It has several components that are more fully developed than in our first two examples, and it has some unique elements, such as its cooperative nature, its scale, and its efforts to address several components of the health care system at one time.

The Concept

The Alliance has taken a more wholistic approach to controlling health care costs than our other two examples and than most other efforts. It has focused on both the short and long terms, on both the consumer and the provider, on quality as well as cost, and on reforming health care not only for members, but indirectly for non-members as well. It addresses these topics in a literally cooperative way. Firms involved are members of the cooperative, cooperatively sharing responsibilities and the savings realized. The cooperative has a fundamental tenet -- patient-provider-payer cooperation -- as a means to deliver better and more appropriate health care. The challenges the Alliance has taken on are formidable, but it is approaching them in a rational order that allows it to tackle new problems as old ones are addressed.

Its History

The Alliance started as the Madison Area Health Care Coalition in 1983. Its members were concerned with limiting the growth of health care costs. It had modest success. In 1987, the members considered changing the organization to a preferred provider organization to realize some gains in pricing. The director at the time, Josephine Musser, now Commissioner of Insurance for the State of Wisconsin, persuaded the members that a PPO solution would only yield short-term benefits. She argued persuasively that more than purchasing had to be pursued if the Coalition was to really address health delivery issues. It took three years of study and debate to create what is now the Alliance.

When the employers in the Alliance undertook the feasibility study, they discovered two key conditions that influenced the design of it. One of these is that employers have no information on the pricing of health services. They get pricing of insurance policies, but they have no idea what doctors or hospitals are really charging for the variety of services that they provide. Without such information, employers cannot make informed decisions on such issues as which doctors should be utilized in order to control costs. Their second finding related to the first: In what appeared to be a very competitive market with lots of providers offering their services, there was no real price competition. Fees for services ranged widely with seemingly little reason for the differences and few, if any, choices by consumers being made based on the price differentials. In a supposed market economy, the market was not functioning because the consumers had very incomplete information.

The pre-Alliance group also discovered, as it surveyed the entire U.S., that no one was taking a comprehensive approach to health care. Organizations like our first two examples picked up pieces, such as a network of providers with lower prices, a wellness

program for members, some tracking of fees, and the like. But no examples surfaced that contained these elements and a number of others that are explicated below. That helped give the organization the impetus to launch the new initiative.

In 1990, the Alliance was founded. Fourteen companies with 6,000 employees signed on originally, followed by six more companies a few weeks later. The doors then shut until these cooperative members were convinced that the direction in which they were headed was appropriate. The original members had to invest $250,000 for the launch. They created a board of directors consisting of seven of the founders, Ms. Musser, and two representatives of small-business members. Once they put major elements into place, the doors reopened. Substantial growth has occurred ever since.

The Alliance initially served only Dane County. As it developed and became more certain of the benefits and transferability of its model, the Alliance has branched out. It is now actively working in Appleton, Eau Claire, Janesville, LaCrosse, and Wausau. It has gone beyond the initial model of health care providers to include a pharmacy network and a Worker's Compensation network, both of which will be explained further below. And the basic model has caught the eye of Governor Tommy G. Thompson, who is using it (and its director) as the model for his initiative, The Wisconsin Health Care Partnership Plan.

The Services

The Alliance has many initiatives operating at the same time. These somewhat disparate elements can be categorized into four basic service areas. Each is explained below.

Data collection and analysis

As both SEARCH and MCW-JC discovered, there are wide variations in fees for health care services. Few, if any, purchasers knew of the variation. The first step of the Alliance was (and is) to collect extensive data on the cost and composition of health care utilization. It then analyzes the data in detail and produces monthly and quarterly reports for employers as to where health care dollars are going, in order to show employers how they are doing relative to others and to illuminate where they may be able to influence employees in their wellness efforts or health care purchase decisions. Employers learn if there are opportunities to use deductibles or co-payments to steer employees away from certain uses, such as the emergency room or certain forms of surgery, or toward uses like regular check-ups or specific forms of care. Employers learn if there appear to be some occupational hazards of which they were unaware. Employers also learn if their employees are making similar or different purchase decisions than employees of other firms.

The Alliance does not adjudicate the bills as they are sent to it. All providers send information on procedures and rates (the bills) to the Alliance for any services provided to employees in the plan. The Alliance processes these bills in one to two days and then passes them on to the payers, be they insurance companies or employers who self-insure. It not only records the information, it also checks and, where necessary, restates the bill for the amount that Alliance members are to be charged for specific procedures. In addition, if the Alliance sees patterns in utilization such as a high incidence of respiratory treatment, it will note whether it is due to infections, cancer, or whatever so that employers will be notified of more specific incidents than are reported by insurance carriers with their more general categorization of service types.

Consumer education

The second major component of the Alliance approach to health care cost containment is consumer education and advocacy. The component just explained examined how employers are turned into much better informed payers for health care services. The next key part of both the equation and the partnership involves making the individual consumer much smarter about all aspects of health and health care delivery. The Alliance sees the informed consumer as fundamental to a successful program. Consumers must know how to choose a doctor, how to learn of their options from health care providers, how they are to be charged for services received, how to interpret a bill, and how to take better care of themselves and their families. Consumer education involves several elements, including common, printed communication.

Beyond printed handouts, the first element is a telephone hotline to a nurse. The 800 number is staffed by nurses who can answer procedural questions on health or how to choose a doctor as well as how to interpret a bill. The staff explains benefits, which plans take new patients, whether members should see a family practitioner, and whether a patient should have a mammagram or some other procedure. As the availability of the telephone line has become better known, its use has increased dramatically.

The second element of the consumer-education component is education of the consumer at the worksite. The Alliance takes doctors who volunteer out to specific worksites to inform consumers on how to seek and get appropriate care. The doctor role-plays to show how a patient can best talk with a doctor. Since many patients have limited experience with provider interaction, the modeling of behavior has proven to be extremely informative.

The third element of consumer education involves identifying and serving the needs of specific populations. The first population so served is that of pregnant women. The Alliance created a program called "Baby Love." It provides prenatal service care, including a screening questionnaire for risks involved in pregnancy, referral to a doctor, assistance in finding other materials the women need that relate to their pregnancy, and gifts and coupons developed with cross-competitive suppliers to further assist the mothers-to-be. When other, specific sub-populations are identified, special programs will be developed for them as well.

The fourth element is still under development. It is called a "quality composite system." It is intended as a means of measuring the quality of service provided by various potential providers of services to pregnant mothers or other sub-populations. Service providers are to be ranked by outcome and cost. The intent is to create a more conscious consumer who will make better decisions about health and health care consumption. An example of this is the current Worker's Compensation analysis, detailed below.

Direct provider contracts

The Alliance has assembled a network of health care providers who have agreed to work with the Alliance and its employer members. Given the nature of the Madison market, the network is somewhat unique in that it encompasses 98%-99% of all providers in Dane County. This has occurred because Dane is served by three enormous clinics: Dean, Physicians Plus, and the University of Wisconsin. The first two are the 23rd- and 25th-largest clinics in the country. All three clinics are tied to specific hospitals, to which each makes all referrals. The Alliance also has contracts with a few non-affiliated groups that constitute much of the rest of the service providers in the county.

The Alliance does not have the base number of employees to demand a discount on service fees. It claims that it pays the "market rate." But that market rate is not what each provider wants to charge; it is the fee that the Alliance says it will pay. That fee is determined by a detailed analysis of the fees charged by all providers and a decision to pay less than the maximum charged, but no less than the minimum. The fee is determined by the use of multiple criteria. The Alliance starts at the mean for a specific procedure and examines the range, the percent of doctors who receive the highest fees, and several other measures. It employs a set of generally accepted multipliers that take into account the difficulty of the procedure involved. For the hospitals that have agreed to participate, the Alliance contracts with them using the predetermined rates used by the government's major medical programs, which are based on payment categories called Diagnosis Related Groups (DRGs).[10] The Alliance has tried to find the real cost of providing services to regular patients, ignoring Medicaid and Medicare patients and charges, and has said that they will pay them. The twist is that one of the hospitals in Madison, St. Mary's, has the lowest costs in the state. The Alliance has told the other hospitals that it will pay them the rate for regular patients that it is charged by St. Mary's. This payment schedule was not immediately well received, but the Alliance is moving in this direction as it approves payment for hospital procedures.

Community Quality Initiative

The fourth basic component of the Alliance approach is what it terms the Community Quality Initiative. It involves a partnership of employers, providers, employees, and Alliance staff who work together to identify areas of health care provision that should be examined closely to see whether changes can be made that would yield benefits in both cost containment and quality improvement. The Alliance has constructed both a Quality Forum of 10 members of the Board who spend six hours a month on the effort and several Quality Councils, whose members spend four to six hours per month on quality issues. The effort is based on W. Edwards Deming's model of process improvement so central to the industrial revitalization of Japan. All members are educated about his seven-step model. Teams then try to apply the model of continuous process improvement to specific health care concerns.

At the outset, four project teams and topics were chosen. Each was chosen because it appeared that money could be saved if modifications were made to procedures in that area. The topics included the pulseless and how to deal with them, patient registration procedures, standardized benefits, and standardized forms. The teams would take a topic like patient registration, flow-chart the process, and examine where procedures might be changed to save money yet serve the patient at least as well. Team members benefited not only from a better understanding of where savings might be realized, but they also became more appreciative of the roles others played in the process of health care provision. They began to say things like, "All that just for a sore throat."

As they have tackled various subjects, the roles of the teams and board have evolved. The board is now attempting to focus on the root causes of health care needs and costs. They react to talks and papers. The teams examine new topics as they become generally accepted as areas that need a more detailed examination. The topics may be rather narrow, such as why hospitals are always using a dye for tests that is 100 times more expensive than the alternative when the expensive dye is needed on only a selected few patients. Or they can be broad, such as how can the system counter the HMO legacy of

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10 *See* U.S. Department of Health and Human Services, Health Care Financing Administration, *The Medicare 1993 Handbook* (Washington, D.C.: Government Printing Office, 1993), p. 16.

"we'll take care of you; this is a benefit, so use it." Such a legacy undermines much of the effort to promote assumption of greater responsibility for one's own health.

Cost Containment

Alliance members think health care costs must be contained by employing a variety of tools. They have already learned they can reduce costs by focusing on specific issues in delivery -- such as how one registers and how often one must register, or what dye is used, or the fact that everyone in the system uses the same form -- cutting inefficiencies in form reproduction and completion. But there are a number of other steps that are yielding cost savings.

One that was mentioned earlier is the reduction of variation in charges. The basic approach is to eliminate the high-priced vendors by publicizing who they are and refusing to pay their high fees. The Alliance has reduced hospital charges 10% and physician charges 16% in aggregate by determining what is a defensible market fee and paying it. This step sounds simple, but it is not. Not only does it involve monitoring the tens of thousands of transactions and bills, but also it involves monitoring unusual treatments, getting employees to challenge costs, and checking to make sure providers have not "up-coded" procedures.

Unlike an HMO, which usually must approve a procedure or service before it is rendered, Alliance members get treatment. The Alliance comes into play when the bill is submitted. Those that are in the acceptable range are approved and sent on. Bills that seem high are handled in a variety of ways. Any charge that is greater than 150% of the mean fee is looked at and changed to a smaller fee. The Alliance refuses to pay it unless it is explained. This procedure has yielded substantial savings. The Alliance has also gotten patients to challenge the bills by telling them that they will only pay a modest portion of the bill because the fee was out of line. One example resulted from a $750 procedure of inserting a birth control device in an arm that took 45 minutes. The Alliance said it was a $150 procedure and that the patient must pay the difference. That tactic creates some clients who take their anger out on the providers who have overcharged them, often resulting in lower bills.

The fact that the Alliance is constantly monitoring all bills and procedures may also serve to reduce costs in an unmeasurable way. Providers who are being closely watched are likely to be more careful in what they do. They are less likely to say that a more expensive procedure was needed or used (upcoding) when it was really not needed or used. The Alliance watches for patterns of use and billing for specific illnesses. It uses software to see if some providers are billing for one intermediate and five comprehensive visits to the doctor for a specific condition when most other physicians are charging for one comprehensive and five intermediate visits. The Alliance is pushing for the universal adoption of the "Harrington Treatment System," a clearly defined system of treatment that all providers should use (and for which they will be paid).

Yet another mechanism that the Alliance is implementing to ensure that cost savings also help to produce higher-quality care is a series of examinations of outcomes. For example, it takes areas like babies, hearts, and backs, creates a list of patients who have been treated in the most recent six-week period, and then asks them to complete and return a patient-satisfaction survey. The Alliance also examines readmission rates and complications within 30 or 60 days of previous treatment. Staff then try to determine why rates are different and whether some hospitals should change certain procedures based on the unintended outcomes.

The Alliance has not had enough experience with these outcomes-based analyses to know how much help they will provide. But it is convinced that greater involvement of the consumer is key to reducing health care costs. The Alliance believes consumers can do much more to contain costs and demand quality if they are better informed. Consumers, if informed, can make better decisions on what they want done, when it should be done, where it should occur, and by whom. If doctors, procedures, hospitals, and the like can be statistically rated and that information can be well disseminated, then much more informed health care decisions can -- and, the Alliance hopes, will -- be made.

Providers are also likely to be more careful in avoiding duplicative billing. Duplicate billings are expensive. They require administrative time to identify and challenge. On a monthly and quarterly basis, the Alliance examines the filings to see which providers are really out of line on the number of duplicate billings. It challenges those that are duplicating to reduce their rates and is careful to avoid double payment.

Long-Term Savings

As the Alliance looks to longer-term savings, it is acutely aware that much depends on the health of its clientele. If its clientele takes good care of itself, then long-term care costs are likely to be lower. The Alliance has begun to take a series of measures to create a system that should change behavior and thereby reduce health care costs.

To help the Alliance prepare for future care needs, each new adult covered by the Alliance is asked to fill out a health risk appraisal form. It now uses a national survey form known as SF36, or short form 36, which has been analyzed for many years. From the patterns that have been established, the Alliance is able to predict quite accurately expected levels of health care utilization. The information can be used both to prepare providers for expected levels of utilization and help steer employees to appropriate care or preventative measures.

The Alliance has recently begun to actively use methods of preventive care. It is working to develop schemes that encourage patient behavior change. One of the first programs deals with pregnant women. The Alliance is initiating contracts with the women that say that if the women go to all of their appointments, do not smoke, do not drink, and otherwise follow their guidelines, it will waive the co-payment at time of delivery. The Alliance strongly believes that it must develop many such schemes that will change behavior through the use of incentives.

The Alliance is also hoping to modify physicians' behavior by educating them about standard practices. The first such area in which it has chosen to do so is the Caesarean-section operation. In the U.S., some 24% of babies are delivered by C-section. In Madison, the rate is an enviable 17%. That is fine. But the practice that the Alliance wants to modify is that of delivering second and subsequent children by C-section when the initial child was delivered that way. In Madison, almost all children are repeat C-sections, whereas nationally it is only 37%. The Alliance undertook a survey to determine why the discrepancy exists and discovered that the patients did not know they had the option and that since the benefit plan paid, there was no cost disincentive to the more expensive and risky C-section. The Alliance initially approached this by alerting women that they do have an option and informing the doctors that the standard practice nationwide was to avoid C-sections whenever they could. As this practice is changed, costs will be saved and better care should be provided.

The approach the Alliance takes on subjects such as the C-section is one of education, not bullying. The doctors make the decision. They maintain control of the

medical decision, which pleases them. But their increased knowledge combined with that of their patients should lead to behavior modification.

On a larger scale, the Alliance is working toward three objectives:

- increasing the quality of health care services;
- increasing employer and employee involvement in health care decisions; and
- decreasing the variation in the provision of health care services.

If these can be achieved, not only will quality increase, but overall health care costs will decrease.

The Alliance is also attempting to reduce administrative costs by being the sole source of help and by relying to a greater degree on the consumer. The Alliance is to be consulted by both the physicians and the patients. Middle men and women are eliminated. Double-checking by an intermediate group and the payer is eliminated, reducing the costs of redundancy. The key control mechanism here is the consumer, who is being trained to be a watchdog of the system. How well this works remains to be seen, but the consumer's role is central.

The Alliance is also trying to reduce some of the administrative costs associated with providing health insurance. The Alliance saves money by doing some of the marketing of the plan, paying for employee education, and being systematic and efficient in handling the claims paperwork. It is the hope of the Alliance that by assuming and reducing such costs, the insurers and the employers will have to pay less for the insurance portion of the system. The Alliance also hopes to reduce the number of insurance options employers have. The Alliance must currently service 38 different insurance companies, each with different forms. If that number could be reduced, administrative costs would also be reduced.

Despite the number of initiatives that the Alliance is undertaking to reduce health care costs, it believes those initiatives will not succeed until they have significantly modified the behavior of the consumer. The consumer must exhibit responsible behavior, both in self-maintenance and in demands made on the health care system. An estimated 85% of visits to physicians are for ailments that are self-healing and do not require medical attention. If consumers could be better educated as to when they should really contact doctors, the demand for services, for administrative costs, for facilities, and so forth would be substantially reduced. Until the Alliance and all others involved in health care cost containment can alter consumer behavior in these respects, all cost-containment efforts will falter after the initial gains.

Two additional initiatives have recently been launched that are aimed at further reducing costs. One is a pharmacy network that is intended to provide services at reduced cost and with greater similarity of service than may occur today. The second is a worker's compensation network. The Alliance is attempting to learn which patients referred for worker's compensation claims recover faster and at less cost to the system. It is seeking to identify those physician groups that deliver better outcomes in terms of cost and time. It then seeks to publicize these providers, so that employers and other providers learn of them and take the next logical steps. If this works, the Alliance will attempt to replicate the analysis and publicizing of results with the treatment of other types of patients. The basic notions are that providers are being monitored to prove that they are indeed better than the competition and that the best results will be widely publicized to influence purchase and practice decisions.

Two other areas are also under development. They are Alcohol and Other Drug Abuse/Mental Health, and Chiropractic Care. The same approach will be taken to these topics. Both will be examined to determine what changes would be appropriate to reduce costs, improve quality, or both.

Underdeveloped Elements

The Alliance model is the most comprehensive of those analyzed. It goes well beyond what HMOs or PPOs generally do, and it goes beyond what the other two alternatives are doing. SEARCH and MCW/JC may move to take more of the steps that the Alliance has already undertaken, especially the much more fully developed consumer education and formalized consumer advocacy. At this point, though, it would appear that the one area that has not been formalized in the Alliance is the use of the gatekeeping, primary-care physician. As noted above, national studies indicate that use of such a person is very likely to reduce hospitalizations and other related costs. Other than that, the Alliance seems to be incorporating the latest in thinking on what is needed in order to contain health care costs.

An area that could be bolstered further is that of enrolling small businesses. The cooperative nature of the organization and the savings that have been realized make it a natural ally of small businesses. Although enrollments of such businesses have been on the increase, to really be successful in thwarting federal reform efforts, small businesses must participate to a much greater degree than they have to date. The Alliance is spending more money on marketing than in the past. But additional funds and better outreach methods seem necessary if it is to increase its coverage as much as it would like.

Replicability

Can this model be applied to other markets in Wisconsin? The most obvious response is yes, although perhaps not all markets. The response is obvious because the Alliance has expanded from Dane County into five other markets that are structured somewhat similarly. Those markets -- Appleton, Eau Claire, Janesville, LaCrosse, and Wausau -- are all somewhat limited in scale and have few large providers with whom alliances can be formed. At this point, the Alliance is best replicated in markets with two or three hospitals and where there are large physician groups. Dealing with a large number of small physician groups is thought to be too consuming and expensive because of all the contracts to be negotiated and subsequent interaction required. And the system works better where there are already "natural" relationships between primary-care physicians and specialists.

Milwaukee, in other words, is thought to be a difficult market to enter. With so many hospitals and provider groups, the enrollment task alone seems daunting. There are certainly elements of the approach that are replicable, but the neat control of having some 98%-99% of physicians on board is highly improbable. More thought needs to be given as to the prescription for Milwaukee-area health care cost containment.

Meeting the Needs of Small Business

The majority of original partners in the Alliance was made up of large employers such as Oscar Mayer, Rayovac, American Family Insurance, and the like. The leaders of SEARCH in Sheboygan are large employers. The MCW/JC plan is with a large employer. These employers have the resources to invest to try to find acceptable ways of addressing health care costs. They will not be ignored by the system. Small businesses, on the other

hand, do not have the resources to search for alternatives, and providers and insurers tend to ignore them. If alternative programs are to have a beneficial impact on businesses, they must address both large and small employers. At this point, both SEARCH and the Alliance can do so.

The Alliance admits that its setting of rates has a negative impact on non-participants. Non-Alliance members are likely to pay higher rates to compensate for the lower rates which the Alliance was able to set. This could be particularly hard on non-participating small businesses. In order to not "beggar thy neighbor," the Alliance is attempting to include small businesses in its membership. It wants to create a small-group product that it would market to small businesses. It is attempting to line up a modest number of insurance companies that would sell to small employers. The package it would sell would be pre-approved by the Alliance. The Alliance would assume the costs of several aspects of selling and servicing insurance, such as marketing, educating employees, monitoring the utilization of services, and the like. The result would be a lower-cost policy for employers. Based on past studies, the savings could range from 10% to 40%. That would be a significant achievement and definitely help small employers. Furthermore, the employers would benefit from all other aspects of the Alliance effort to control health care costs.

Alliance Operations

The Alliance is a non-profit cooperative of employers. The members "aggregate and utilize health care purchasing power to identify and contract with quality, cost-efficient providers." The Alliance staff is supported by the access fees it charges members for each employee enrolled each month. The Alliance processes all the claim information from providers, enters it into a database, reprices the claims with the Alliance-negotiated fee, sends the claim on to the appropriate payers, analyzes the utilization of services, educates employers and employees, and reviews new ways to further reduce health care costs. For these services, it receives a fee. The Alliance would also like to receive a share of the claims savings, the reduction in employer cost, but that is not yet possible. The notion is that the savings are significant.

As a non-profit cooperative, the Alliance is not seeking to increase its margin or its total profit. It is seeking to use its resources to the greatest advantage to serve its members by helping to provide them with higher-quality and lower-cost health care. It use its fees to cover operating expenses and to launch new quality initiatives that may yield further rewards. The model of cooperation permeates its approach.

Conclusion

The three models just reviewed have a number of common elements. To aid in the understanding of these elements, a summary of them has been assembled as Chart 2 on the next page. As the chart shows, fee reductions, the lack of mandatory pre-approval for access to health care services, the lack of systematic challenges (utilization review), a move toward wellness programs, and the presence of incentives to modify provider behavior are now common. Other elements, such as the use of a primary-care physician as a gatekeeper, the use of co-payments or deductibles to increase consumer involvement in health care decisions, free choice of doctors, employee health screening, and incentives to modify consumer behavior are shared at this point by at least two of the models.

CHART 2: Summary Characteristics of Alternative Models

Potential Elements	Search	MCW/JC	The Alliance
Method of fee reduction	Volume discount	Negotiate to standard national fee	No steering: accept lower, "fair- market" rate
Deductibles & co-payments	Yes, to steer to network and to change behavior	No	Yes, to change consumer behavior
Basis of fee structure	Negotiated low rate	National McGraw-Hill fee schedule	Low-cost providers in service are modified
Pre-use approval	No: but must see primary care physician	No: but must see primary care physician	No
Utilization review	No, monitor useage and prices	No	No, monitor useage & prices
Gatekeeper	Moving toward primary-care physician	Yes, primary- care physician	No
Degree of choice of doctors	Complete. Pay difference if outside network	Limited. Use those on approved network	Almost complete
Wellness component	Not systematic; only some employers	Yes, emphasis on health assessment	Yes, strong
Employee health screen	No	Yes, all employees and spouses	Yes, must complete at entry
Consumer involvement	Very limited at this point	Limited, but should increase	Yes, central to model. Challenge costs; make informed decisions
Incentives to modify: •consumer behavior •provider behavior	Not yet Steering of patients if cost-effective	To get annual physician. Steering of patients	Yes, to modify various behaviors. Yes-advertising those with better results
Quality emphasis	Not yet	Not yet	In many ways; central to cost cuts & delivery
Analysis of cost elements	Just beginning	Not beyond fees yet	Yes, detailed
Long term fee control	Intermediate- term agree-ments with hospitals; market weight with physicians	Remains to be seen	Through wellness consumer education long-term relationships
Replicable	Yes, if have volume to trade for fee cuts	Seemingly so	Yes. Is expanding to 5 other markets

Yet even with this common ground, it seems certain that no one model will work everywhere. For example, though all three models have lower fees, both the method of securing the reduction and the basis of determining the basis of these fees differ across the three models. The issue of long-term fee reduction is also being addressed differently across the three. And only the Alliance has put an initial emphasis on quality issues.

Containing health care costs is an extremely complex undertaking. Controlling costs, increasing health care quality, and improving access to health care together is an even more challenging task. But that is exactly the task before us. The three new approaches just reviewed seem to be very legitimate attempts to apply what has been learned in recent years about the link between various factors and health care costs. We have learned a great deal about what does not work. It is time we now learned about what *may*.

What these three models seem to have learned that is important for others is summarized in Chart 3 on the next page. The length of the chart emphasizes the fact that health care cost containment cannot be done simply -- it involves many initiatives. First, it involves capturing lower provider fees. Second, it involves the need to have active, informed consumers if a market is to function. And third, it involves the need to develop consumers who take a higher level of responsibility for their own health, thereby reducing their demands on the health care system. Such consumers do not just happen. They must be created through a series of steps, which these models are starting to refine.

CHART 3: Important Characteristics of Program Design

1. Partnership/Cooperation

- Patient/provider/payer must work together

2. Fee Reduction

- Lower initial doctor and hospital fees
- Lower fees of all kinds, *e.g,* drugs and other provisions
- Agreements to limit price increases over time

3. Consumer Involvement

- Consumer education on how, when, where, and why to access the health care system
- Consumer involvement in multiple ways:
  - decreased reliance on doctors for cures
  - use of co-payments and deductibles to ensure informed usage
  - incentives offered to modify health-affecting behavior
  - act as watchdogs over provider decisions and bills
- Wellness program to reduce long-term need for health care services

4. System Monitoring

- Monitor pricing and services provided and inform employers of patterns
- Continuous analysis and publicizing of results to make informed consumers, keeping the market competitive
- Monitoring and analysis of definable outcomes to increase quality, as is being done with Worker's Compensation

5. System Change

- Use primary care physicians as gatekeepers to the system
- Refine the health care system to remove inefficiencies, *e.g.*, standardize forms and benefits
- Educate providers as to the best-accepted practices

6. Continuous Evolution

- Recognize that solutions are evolving as more is learned and be prepared for further change

The jury is still out on these experiments. The steps they have taken seem reasonable, and the early results look favorable. Other employers would benefit by examining what these companies have done and why they consider each component an essential element. Small businesses are not yet well served by these alternatives, but two of the models are working on this aspect. Small businesses must be well served if any of these private-market models are to succeed in the face of larger federal involvement. We cannot guarantee successful outcomes from any of the three models, but based on what we have learned, these alternatives are well worth considering.

ABOUT THE INSTITUTE

The Wisconsin Policy Research Institute is a not-for-profit institute established to study public policy issues affecting the state of Wisconsin.

Under the new federalism, government policy increasingly is made at the state and local level. These public policy decisions affect the lives of every citizen in the state of Wisconsin. Our goal is to provide nonpartisan research on key issues that affect citizens living in Wisconsin so that their elected representatives are able to make informed decisions to improve the quality of life and future of the State.

Our major priority is to improve the accountability of Wisconsin's government. State and local government must be responsive to the citizens of Wisconsin in terms of the programs they devise and the tax money they spend. Accountability should be made available in every major area to which Wisconsin devotes the public's funds.

The agenda for the Institute's activities will direct attention and resources to study the following issues: education; welfare and social services; criminal justice; taxes and spending; and economic development.

We believe that the views of the citizens of Wisconsin should guide the decisions of government officials. To help accomplish this, we will conduct semi-annual public opinion polls that are structured to enable the citizens of Wisconsin to inform government officials about how they view major statewide issues. These polls will be disseminated through the media and be made available to the general public and to the legislative and executive branches of State government. It is essential that elected officials remember that all the programs established and all the money spent comes from the citizens of the State of Wisconsin and is made available through their taxes. Public policy should reflect the real needs and concerns of all the citizens of Wisconsin and not those of specific special interest groups.